

MEASURING FEE-FOR-SERVICE PHYSICIAN & ARNP PARTICIPATION AND CLIENT ACCESS TO CARE - BASELINE MEASURES

Phase One Report to Executive Leadership Team By Access Measurement Workgroup

**Department of Social and Health Services
Medical Assistance Administration**

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Access Measurement Workgroup Sponsors:

Doug Porter, MAA Assistant Secretary
Roger Gantz, Director, MAA Division of Policy and Analysis
Heidi Robbins Brown, Director, MAA Information Services Division

Access Measurement Workgroup Members:

Dr. Nancy Anderson, DMM
Becky Boutilier, DPS
Jean Du, DCS
Daniel Hughes, ISD
Ann Lawrence, DCS
Michael Paulson, DPS
Laura Piliaris, DPA
Cathie Ott, ISD (Workgroup Chair)
Margo Westfall, ISD
Pat White, DCS
Peggy Wilson, DPS

I. EXECUTIVE SUMMARY

Purpose

The Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA) is committed to ensuring adequate access to health care for Medical Assistance eligible clients in Washington State. MAA management and staff, community members, and Legislators have received reports indicating that access to care for Medical Assistance eligible clients is becoming increasingly limited. In January 2003, a cross-divisional MAA Access Measurement Workgroup was formed and charged with the development and production of a measurement methodology that would be used to track in a timely manner access to MAA fee-for-service (FFS) physician and Advanced Registered Nurse Practitioner (ARNP) services on a statewide and county level.

This Phase 1 Report develops a baseline and first of a series of quarterly reports that will track access to FFS physician and ARNP services across Washington. This initial review begins with client and physician and ARNP data from State Fiscal Years (SFY) 2001 and 2002. This period will serve as a baseline for future access trend analysis. Data will be analyzed every six months to provide management with information on emerging changes in access. The Workgroup also conducted an analysis of SFY 2001-02 annual data with SFY 1998-2000 data periods and determined that the SFY 2001-02 data provides a “reasonable” baseline.

Measures

There are a variety of ways to describe and measure access to care. The Access Measurement Workgroup selected the following three measures for quarterly tracking. Absent any established national or public health standards to draw from, the Workgroup chose these measures because they could be derived from existing data sources, are easy to replicate, and are sufficiently precise to capture trends and patterns.

1. Number of active FFS physicians/ARNPs, which provides a basic measure of physician participation;
2. Capacity of the FFS physician/ARNP network presented as a ratio of physicians to 1,000 clients, which provides a normalized measure of access capacity; and,
3. Distribution of FFS visits performed by all active physicians/ARNPs, which provides a measure of workload across active physicians.

There are no absolute workload standards to measure “good” or “bad” access. Rather, these selected measures provide a set of “relative” measures against which MAA can document changes over time.

Findings

- There was a 12.4% increase in active Medical Assistance FFS physicians and ARNPs over the past five-year period, from 11,289 in SFY 1998 to 12,688 in SFY 2002. The increase averaged 3.0 % per year. This increase has continued over the recent quarter when seasonally compared to the same quarter of the previous year.

- There was an increase in both primary care and specialists. The number of primary care physicians increased 4.2% during the period SFY 2001 to 2002, from 6,113 to 6,369. Specialists increased 2.7% during this period, from 6,149 to 6,317.
- The increase in FFS physicians and ARNPs was broad-based during the recent two-year period. Twenty-one (53.8%) counties had an increase, five (12.8%) had no change, and thirteen (33.3%) had reductions. There is a strong correlation between the total population in a county and the number of active FFS physicians and ARNPs.
- The increase in active physicians and ARNPs was offset by the greater increase in eligibles. This caused the ratio of active physicians per 1,000 clients to decrease 25.9% from 43.7 per 1,000 clients to 32.3 per 1,000 from SFY 1998 through SFY 2002. The ratio of active physicians and ARNPs per 1,000 clients decreased 7.9%, from 35.2 per 1,000 in SFY 2001 to 32.4 per 1,000 in SFY 2002. This decrease was due to a 12% increase in clients during this period. These trends occurred for both primary care providers and specialists. These trends also occurred for both adult and children's providers.
- Although the number of active providers has increased, the ratio of active physicians and ARNPs per 1,000 clients decreased 7.9%, from 35.2 per 1,000 in SFY 2001 to 32.4 per 1,000 in SFY 2002. This decrease was due to a 12% increase in clients during this period.
- The reduction in active FFS physicians/ARNPs per 1,000 clients occurred across most counties. Thirty-four (87.2%) of the counties experienced a reduction in SFY 2002 compared to SFY 2001. Garfield, Columbia, Whitman, Walla Walla, Snohomish, and Thurston had the largest percent reduction during this period. There will be a need to continue to do detailed by-county comparisons to ensure there is not further decay in more rural counties over time.
- During the SFY 2001-2002 period, the ratio of primary care providers decreased (7.2%) and specialists (8.5%) also decreased.
- The statewide ratio of active MAA FFS physicians/ARNPs per 1,000 clients appears to be relatively good compared to state health plans. The SFY 2002 MAA FFS ratio was 32.4 per 1,000 clients. In comparison, PEBB managed care plans had a 19.1 per 1,000 ratio and HO plans had 7.2 per 1,000. Only UMP had a higher ratio (40.4 per 1,000) for SFY 2002. Caution is needed in comparing MAA FFS and health plans because of the differences in the measures of active FFS physicians and contracting physicians for health plans.
- There is a significant difference in the SFY 2002 ratio of MAA FFS physicians/ARNPs per 1,000 across counties. It ranges from King County's 65.1 per 1,000 to Douglas County's 0.8 per 1,000. There is not a strong correlation between the size of a county's total population and its ratio of active MAA FFS per 1,000 clients.
- Although there was a reduction in capacity as measured by physicians/ARNPs per 1,000 clients, there was not an adverse shift in the percentage of visits provided by the most active providers. In fact, there has been a slight reduction in the percent of visits provided by the top quartile of physicians and ARNPs over the five-year period. The same pattern holds for active primary care providers or specialists.
- Emergency Room (ER) utilization has been commonly used as an indicator of access to health care services. Increased ER utilization suggests that clients may not have adequate access to primary care. A report in January 2003 supports the relatively stable access found in this Phase 1 Access Measurement Report. The ER Report identified increases in ER

utilization, but the increase was very much in line with caseload growth. On a per-capita basis, total ER utilization held relatively flat.

- SFY 2001 and 2002 will provide a reasonable base period for future comparisons. The average growth in the number of active physicians and ARNPs during the recent two-year period is consistent with the overall average annual growth over the total five-year period, and the reduction in providers per 1,000 clients in SFY 2001 and 2002, due to the greater increase in FFS clients, is comparable to the five-year average reduction.

II. PROVIDER PARTICIPATION AND ACCESS TO CARE: PHASE ONE

The Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA) has developed a set of measures to monitor MAA's fee-for-service (FFS) access to medical care. There are a variety of ways to describe and measure access to care. The MAA Access Measurement Workgroup selected three measures that will provide management with information on the number of physicians and ARNPs that are actively participating in the MAA FFS delivery system, the relative capacity of physicians/ARNPs over time to service clients, and the proportion of physicians/ARNPs that are providing services in a given period. These measures were selected because they can be replicated on a timely and ongoing basis using existing data sources, and are sufficiently precise to capture trends and patterns.

This report provides physician and ARNP measures for State Fiscal Year (SFY) 2001 and 2002. This time period will serve as a baseline for future analysis to assess trends. Beginning in July 2003, these measures will be analyzed every six months to provide management with information on emerging changes in access.

To ensure that the SFY 2001-02 data provides a "reasonable" baseline, the report compares the SFY 2001-02 annual data with SFY 1998-2000 data periods. While this report focuses on MAA's FFS access, the FFS access measures are compared to MAA's Medicaid Healthy Options (HO) managed care program and Public Employees Benefits Board (PEBB) programs to provide a more comprehensive picture of provider participation.

These measures by no means speak to definitively good or bad access. Instead, they provide a set of "relative" measures for which MAA can document change over time. For example, it is better to see an increase in the number of active physicians/ARNPs participating in care to Medical Assistance clients, and it is better to have an increase in active clinicians per 1,000 clients over time, which indicates increased capacity. The distribution of visits provided across physicians/ARNPs gives an indication of the percentage of active clinicians who actually care for the majority of clients. Ideally, the percent of visits should be the same as the percent of physicians providing these services.

A. ACCESS MEASURES AND DEFINITIONS

The following section provides a definition of the three access measures. It also includes a description of the data sources and definitions used to generate the measures, and a discussion of limitations and potential challenges in using these measures.

1. Number of active FFS physicians and ARNPs.

- Active FFS physicians and ARNPs are defined as any physician or ARNP who provides at least one patient visit in that quarter's time period.
- The number of active FFS physicians/ARNPs per quarter is compared over time with Medicaid HO managed care, state employees' PEBB managed care and state employees' Uniform Medical Program (UMP) to assess if there is a significant relative loss or gain in physicians serving MAA clients, compared to clinicians serving HO, PEBB and UMP clients.

It should be noted that the count of FFS physicians/ARNPs is based on active performing providers in a given period, while HO, PEBB and UMP counts are based on the number of contracting physicians in the health plan's network during that period. Therefore, it is more appropriate to compare the directionality (more or fewer providers between periods) across the plans and FFS than comparing the absolute counts.

2. Capacity of the FFS physician network by measuring ratio of physicians and ARNPs to 1,000 clients.

- The measure of providers per 1,000 clients gives a clearer picture of access because it accounts for changes in the number of FFS clients over time. For example, if the number of participating physicians and ARNPs is increasing at a slower rate than the growth in FFS clients, this would suggest that there is less access to care.

The ratio of active FFS physicians/ARNPs per 1,000 clients is compared over time with HO, PEBB and UMP to assess if there is a significant relative loss or gain in physicians serving MAA clients, compared to clinicians serving HO, PEBB and UMP clients. As described above, the comparisons are based on directionality (more or fewer providers between periods) across the plans and FFS and not absolute counts.

3. Distribution of FFS visits provided across physicians and ARNPs.

- The distribution measure relates the percent of visits to the percent of active physicians and ARNPs. It captures the degree of service concentration among FFS providers. Ideally, each active clinician provides the same number of visits. In that situation, the percent of visits provided would be equal to the percent of physicians/ARNPs providing services. For example, 25% of the visits would be provided by 25% of the physicians.

All three measures are compared on a statewide and by-county basis to identify overall trends and specific county issues.

The three measures are tracked for two time periods. The measures will be compared for the most recent 12-month period to the preceding 12-month period. The 12-month measures will be a moving average. The other compares the most current quarter in the year-to-date with the corresponding prior year's quarter. In analyzing current quarterly changes, it is important to account for seasonality in active providers. Based on an analysis of physician visits and ER visits, the second (October through December) and third (January through March) quarters have more visits in part due to illnesses that occur more in colder winter periods. Therefore, comparisons will be made on a current quarter to prior year quarter basis, as well as an average annual year basis.

The three measures are separately compared for FFS primary care and specialty care. They also are compared for adults and children. MAA is currently providing health care to some 873,000 persons, and family planning to roughly 100,000 persons. Some 407,000 persons receive care through FFS. About 60 percent of the FFS clients are adults and 40 percent are children.

Data Sources and Definitions:

To establish a baseline, SFY 2001 and 2002 data were drawn from the Medicaid Management Information System (MMIS) Decision Support System (DSS). The following criteria were used to generate FFS provider counts:

- Provider Category of Service 20 through 30 includes physicians (MD) and Doctors of Osteopathic Medicine (DO).
- Provider Type 93, Advanced Registered Nurse Practitioners (ARNP) were included.
- “Active providers” is the number of physicians or ARNPs that had at least one patient visit in a given period. The reason for adopting this definition is to fully capture information for the distribution of visits measure.
- Primary care providers were defined as those who were in the following four categories: general practice, family practice, pediatrics, and internal medicine. Specialty care providers were those who were outside the four categories.
- Participating physician and client enrollment data were drawn from the MAA Division of Program Support’s Integrated Provider Network Database (IPND) for the Medicaid HO managed care, the state employees’ UMP coverage, and the state employees PEBB managed care program.
- This report focuses on Medical Assistance’s FFS clients and providers. Most (92%) of Medical Assistance’s FFS clients are Medicaid Categorically Needy (M-CN) beneficiaries. The other FFS clients are covered through the Medicaid Medically Needy (M-MN) program (4%), state-only Medical Care Services (MCS) program (3%), State Children’s Health Insurance Program (SCHIP)(.4%) or Refugee Assistance program (.2%).

For periods through SFY 2002, the FFS client counts include the Children’s Health Program (CHP) and State Family Assistance (SFA) for non-citizen clients and Medically Indigent (MI) program for uninsured, low-income persons requiring emergent medical care. The CHP and SFA programs were terminated in October 2002. Eligibility and service counts for these clients will not appear in the second quarter of SFY 2003 and thereafter. The MI program terminated in July 2003, and counts for these persons will not appear after the fourth quarter of SFY 2003.

- The number of Medicaid FFS clients was calculated with the removal of Family Planning, Take Charge Program, SLMB-Only Medicare beneficiaries, and ESLMB (QI-1s) Medicare beneficiaries. The Medicare beneficiary groups were removed because Medicaid only pays for their Medicare cost-sharing. Part B physician services are covered by Medicare. Family planning clients were removed because their benefit coverage is limited to family planning services and not routine physician care or specialty care.

Data Limitations and Potential Challenges:

- It should be noted that there are limitations inherent in the IPND and the accompanying comparisons. While FFS providers can be defined as “active” based on claims activity within

a given time period, the IPND provides an account of providers within a network and no conclusive measure can be drawn regarding their activity.

- IPND reporting leads to routine spikes prior to the beginning of a contract period. Plans are asked to submit information regarding providers they plan to include in their network. At the time of contract negotiation and signing, actual provider participation may vary.
- IPND data prior to the end of FY 2000 have questionable validity. As a result, only FFS data was used for FY 1998, 1999, and 2000 analysis.

B. FINDINGS

Measure One: Number of active FFS providers.

Figure 1 shows the statewide comparison of active physicians and ARNPs for the eight quarters spanning SFY 2001 and 2002. The comparison is for Medicaid FFS, Medicaid HO managed care, PEBB managed care and PEBB UMP FFS.

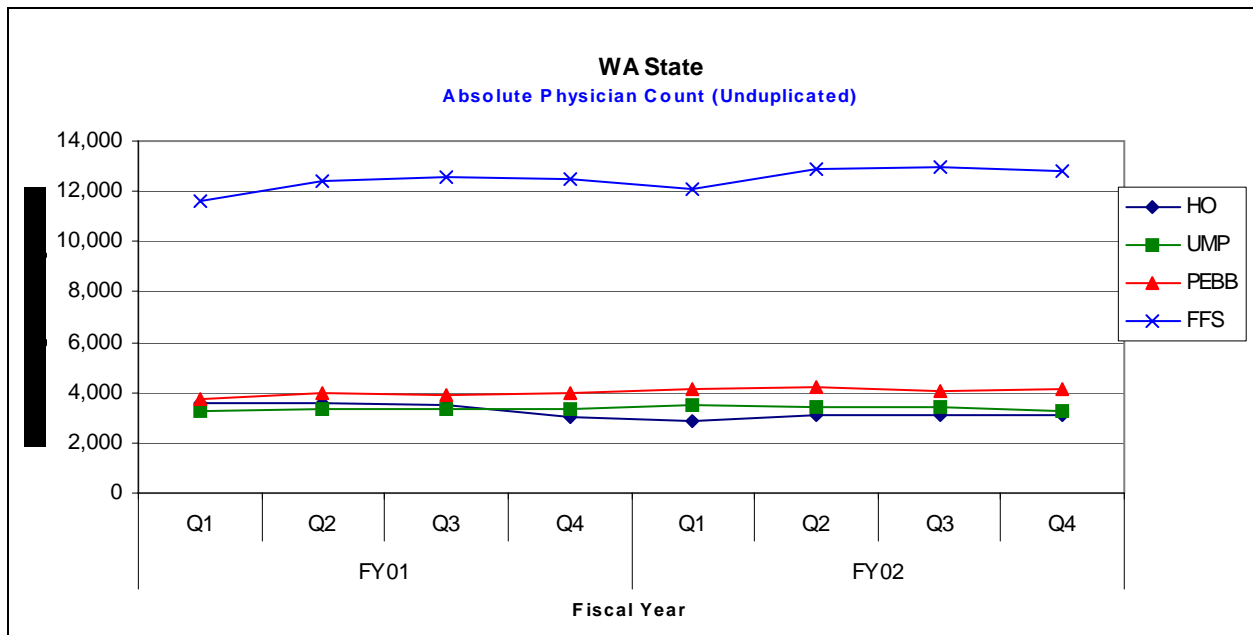


Figure 1 (A3): Active physicians per quarterly basis.

The number of active participating FFS physicians and ARNPs increased 3.3% between SFY 2001 and 2002, from 12,261 to 12,687. In comparison, UMP physicians increased 1.9%, from 3,321 in SFY 2001 to 3,384 in SFY 2002, and PEBB plans' physician network increased 5.6%, from 3,897 to 4,117. In contrast, the Medicaid Healthy Options (HO) plans experienced a 10.3% decrease over this period, from 3,408 to 3,057.

There is a strong correlation between the number of active FFS physicians/ARNPs and counties' total populations. The 10 largest counties had the 9 largest number of active physicians and

ARNPs in SFY 2002. Similarly, the 10 smallest counties had the 9 least number of physicians/ARNPs.

The increase in Medical Assistance FFS physicians/ARNPs during the SFY 2001-2002 period occurred across most counties during SFY 2002. (See Appendix A for by-county comparisons of MAA FFS, PEBB, UMP and HO physicians.) Twenty-one (53.8%) counties had an increase in average active physicians/ARNPs between SFY 2001 and SFY 2002. Five (12.8%) counties had no changes and 13 (33.3%) counties had reductions. However, only one county (Walla Walla) of the 13 counties appeared to have a material reduction.

The number of active MAA FFS physicians and ARNPs also increased 2.4% during the most recent quarter (April 2002 through June 2002) when seasonally compared (i.e., comparing SFY2002Qtr4 to SFY2001Qtr4). Overall, this increase was also broad-based, with 21 (53.8% of the counties having an increase and 7 (17.9%) had no reduction. However, 11 (28.2%) of the counties did have a quarterly reduction. Walla Walla, Whatcom, Franklin, Asotin and Kittitas had a reduction of 3 or more active physicians/ARNPs during this period.

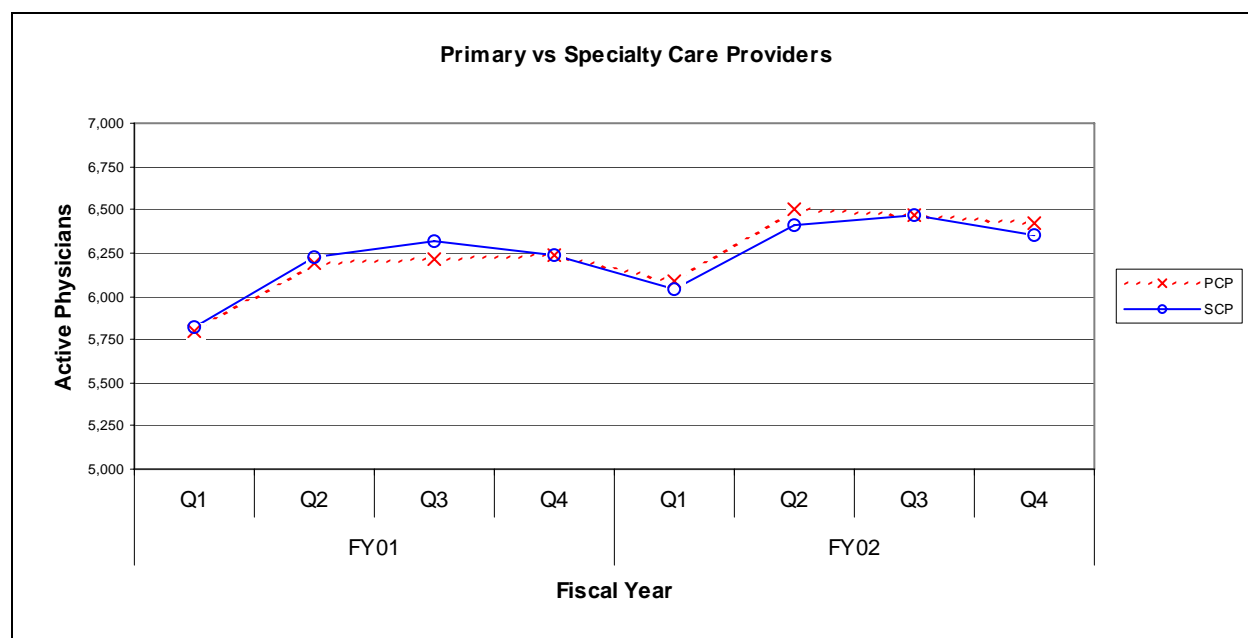


Figure 2 (H1): Primary Care Providers (PCP) and Specialty Care Providers (SCP) who were active in their respective FY and quarter.

Figure 2 shows the number of active FFS primary care providers and specialty care providers in SFY 2001 and 2002. There was an increase in both groups of providers. The number of active primary care providers increased 4.2%, from an average of 6,113 to 6,369, respectively. The number of active specialists increases 2.7% during this period, from 6,149 to 6,317.

Twenty-two (56.4%) counties had an increase in average active primary care providers and 12 (30.8%) had a reduction. (See Appendix I for by-county comparison of primary care providers.) In contrast, 15 (38.5%) of the counties had an increase in the number of active specialists, while 16 (41.0%) had a decrease and 8 (20.5%) had no change. (See Appendix H for by-county comparison of primary care providers.)

Both FFS primary care providers and specialists increased during the most recent quarter. The number of active primary care providers increased 3.0% and specialists increased 1.8%.

Nineteen (48.7%) counties had increases in primary care providers and 11 (28.2%) had reductions. Fifteen (38.5%) counties had an increase in the number of active specialists, while 10 (25.6%) had a decrease and 14 (35.9%) had no change.

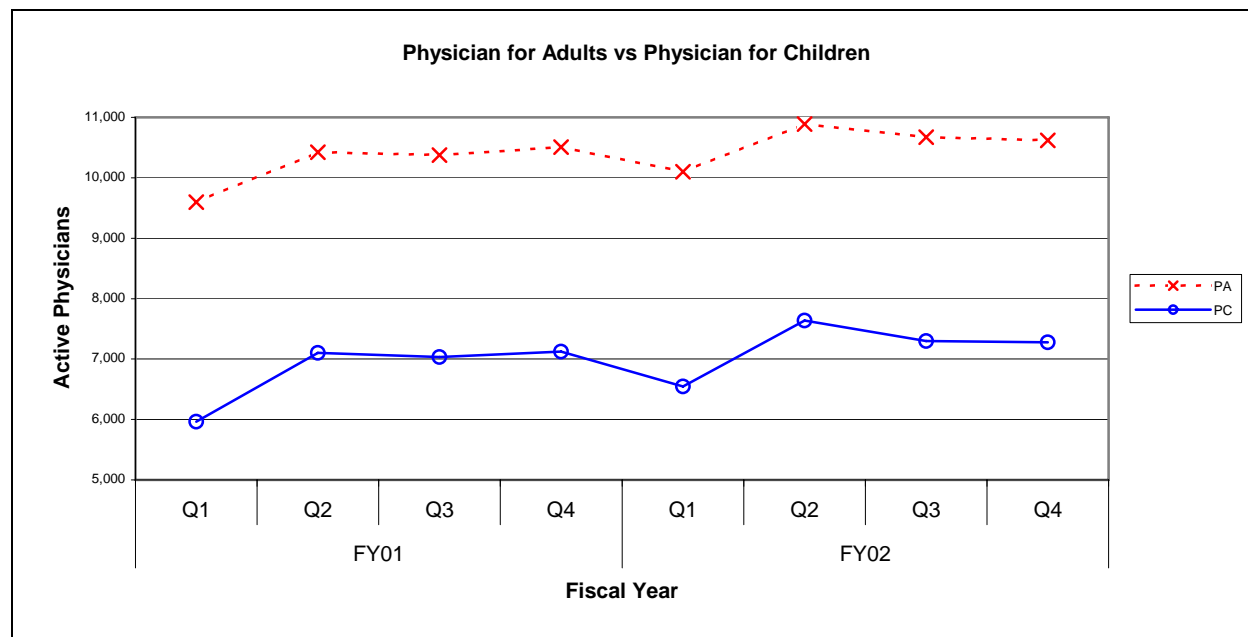


Figure 3 (E3b): Physician Adults (PA, i.e., physicians treating adults) and Physician Children (PC, i.e., physicians treating children) who were active in their respective FY and quarter.

There also was an increase in FFS physicians/ARNPs serving both adults and children during the SFY 2001-2002 period (see Figure 3).¹ The number of active providers serving adults increased 3.4%, from an average of 10,227 to 10,570 for SFY 2001 and 2002, respectively. The number of active providers serving children increased 5.6%, from an average of 6,806 to 7,190 for SFY 2001 and 2002, respectively.

Nineteen (48.7%) counties had an increase in average active providers serving adults and 13 (33.3%) had a reduction. In comparison, 23 (60.5%) of the counties had an increase in the number of providers servicing children, and 14 (36.8%) had a decrease. (See Appendix E for by-county comparison of providers serving adults and children.)

Both the number of providers serving adults and providers serving children increased during the most recent quarter compared to the prior year's quarter. The number of active providers serving adults increased 1.0% and providers serving children increased 2.2%. Fifteen (38.5%) counties had increases in adult providers and 16 (41.0%) had reductions. Twenty-three (60.5%) counties had an increase in the number of providers serving children, while 11 (28.9%) had a decrease. (See Appendix G for by-county comparisons of primary care and specialists physicians.)

Measure Two: Capacity of the FFS physician network presented as a ratio of physicians to 1,000 clients.

¹ The sum of PA and PC exceeds that of total physician count in Figure 1. This excess is due to a certain percentage of physicians who not only provided care to adults but also children (i.e., overlapping of two population groups).

Figure 4 provides Medical Assistance FFS, HO, UMP, and PEBB enrollees over time. It is important to reference these population changes because they are the primary reason for the changes in physicians/ARNPs per 1,000 clients.

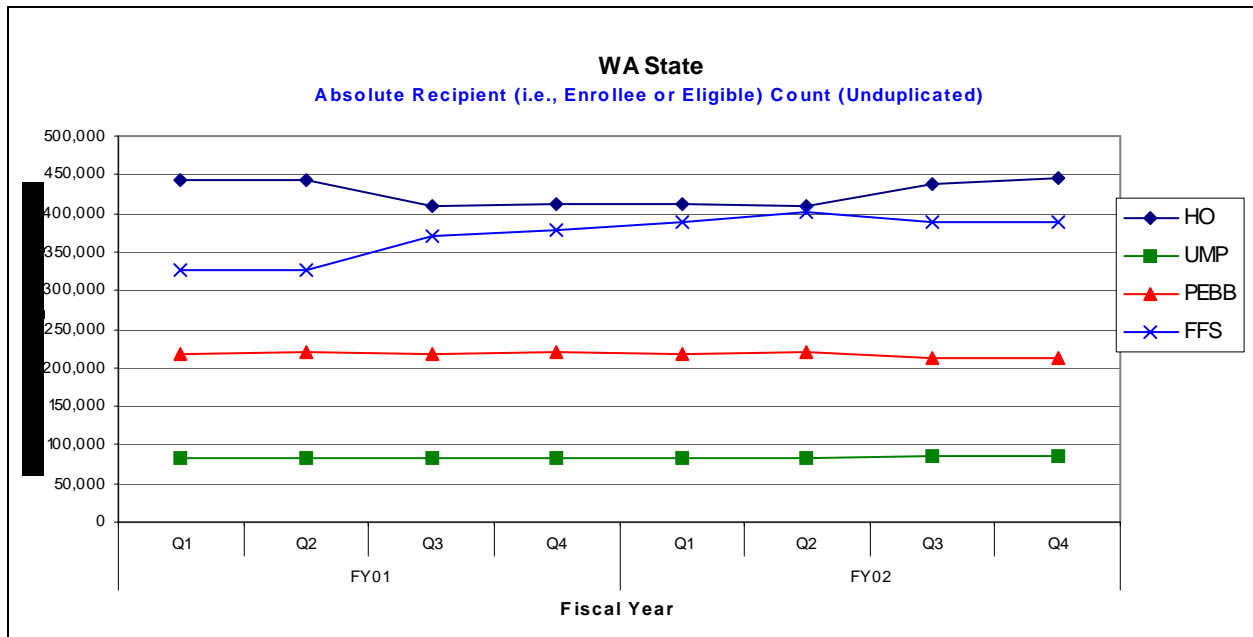


Figure 4 (A4): Eligibles and enrollees on a quarterly basis.

During the SFY 2001-02 period, the Medical Assistance FFS client enrollment increased 12.0% from 349,958 to 392,000. In comparison, the UMP enrollment increased only 0.7%, while HO enrollment decreased 0.3% and PEBB decreased 1.5%.

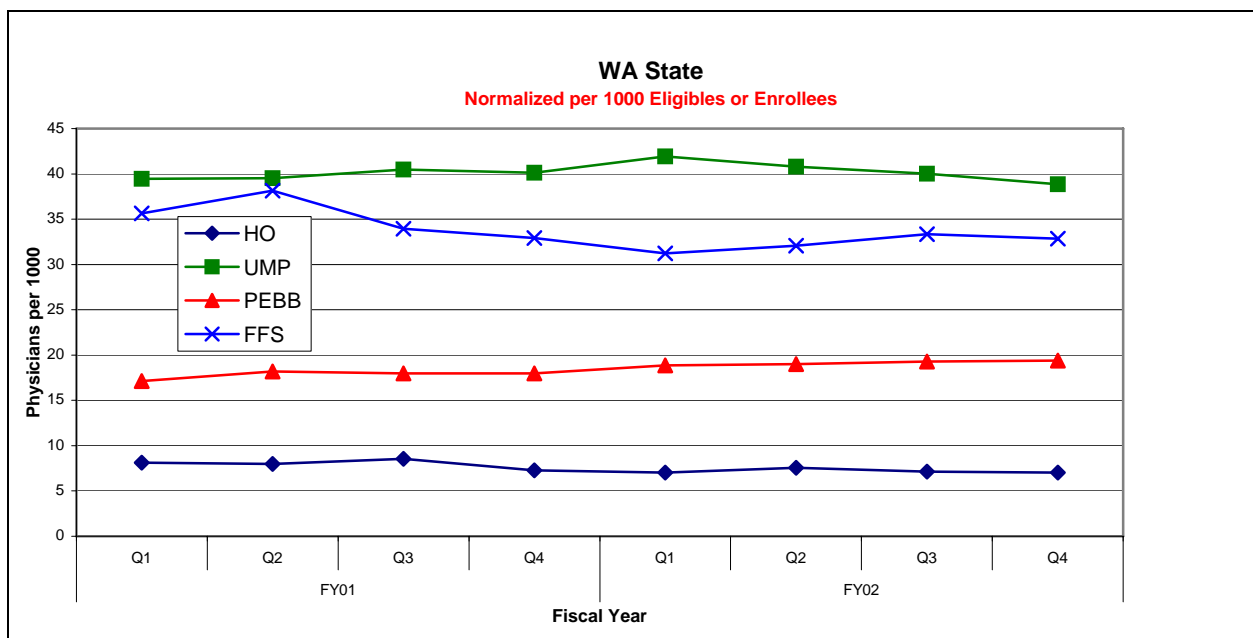


Figure 5 (A5): Normalized (per 1000) trending of active physicians/ARNPs.

Figure 5 shows the statewide comparison of physicians/ARNPs per 1,000 eligibles for the eight quarters spanning SFY 2001 and 2002. The comparison is for Medicaid FFS, Medicaid HO managed care, PEBB managed care and PEBB UMP FFS.

Medical Assistance FFS experienced a 7.9% reduction in physicians/ARNPs per 1,000 during the SFY 2001-2002 period. As was the case over the total five-year period, the FFS reduction was due to caseload growth of 12.0% from SFY 2001 to 2002, which exceeded the 3.5% increase in active physicians/ARNPs.

In comparison to Medical Assistance FFS, HO had a 10.0% reduction in physicians/ARNPs per 1,000 clients between SFY 2001 and 2002. This reduction was primarily due to a reduction in the number of providers. Both UMP and PEBB had increases in physicians/ARNPs per 1,000 clients during this period, 1.2% and 7.3%, respectively. However, these increases were due to both a slight increase in participating providers and either a very small or actual reduction in program enrollees.

Although there has been a reduction in active FFS physicians/ARNPs per 1,000 clients, the ratio appears to be relatively good compared to three other state health plans. The SFY 2002 MAA FFS statewide average ratio was 32.4 per 1,000. In comparison, PEBB managed care plans had a statewide average of 19.1 per 1,000 and HO plans had 7.2 per 1,000. Only UMP had a higher ratio of physicians/ARNPs per 1,000 clients (40.4 per 1,000) for SFY 2002.

MAA FFS Physicians/ARNPs Per 1,000 Clients Compared to HO, PEBB & UMP		
MAA ranking ratio of active physicians/ARNPs per 1,000 clients compared to HO, PEBB and UMP	Number of Counties	Percent of Counties
Ranked 1 st	5	13%
Ranked 2 nd	13	32%
Ranked 3 rd	12	31%
Ranked 4 th	9	23%

Table 1: Comparison of physicians per clients across different plans.

However, as shown in Table 1, there were differences in the ranking of physicians/ARNPs per 1,000 clients across counties. Although MAA FFS physicians/ARNPs per 1,000 clients ranked second statewide, it ranked the highest in 13% of the counties, ranked second highest in 32% of counties, third in 31% of the counties, and last in 23% of the counties.

There is a significant difference in the ratio of physicians/ARNPs per 1,000 across counties. They range from King County with 65.1 per 1,000 in SFY 2002, Chelan County with 55.1 and Benton with 40.0 compared to Asotin with 7.5 per 1,000, Skamania with 3.8 and Douglas County with 0.8. (See Appendix B for by-county comparison for physicians/ARNPs per 1,000 clients.) There is not a strong correlation between the size of a county's total population and its ratio of active MAA FFS per 1,000 clients.

The reduction in SFY 2002 active FFS physicians/ARNPs per 1,000 clients occurred across most counties. Thirty-four (87.2%) of the counties experienced a reduction in SFY 2002 compared to SFY 2001. Garfield, Columbia, Whitman, Walla Walla, Snohomish, and Thurston had the largest percent reduction during this period. Three counties (Garfield, Columbia and Walla Walla) had

actual reductions in the number of active physicians during the period, while the other counties experienced a significantly greater increase in enrollees than providers. (See Appendix B for by-county comparison for physicians/ARNPs per 1,000 clients.)

In comparison, 5 (13%) counties had an increase in physicians/ARNPs per 1,000 clients in SFY 2002. These counties were Lincoln, Adams, San Juan, Okanogan and King.

When seasonally compared, the most current quarter's (SFY2002Qrt4) ratio of providers per 1,000 clients decreased for most lines of business. The MAA FFS decreased 0.3%, HO decreased 3.2% and UMP decreased 3.1%. PEBB had a 7.9% increase. However, PEBB's increase was due to a decrease in enrollment for this period.

The MAA FFS reduction for the most current quarter also was broad-based. Most (76.9%) counties had a reduction in physicians/ARNPs when compared with the fourth quarter of SFY 2001. The counties with the largest percent reduction were Thurston, Walla Walla, Whitman, Columbia, Klickitat, Whatcom, Kittitas, Franklin and Ferry. Except for Thurston and Whitman, these counties had an actual reduction in the number of active physicians and ARNPs.

Eight (20.5%) counties had increases in the number of physicians/ARNPs per 1,000 clients during the current quarter. These were Lincoln, Yakima, Garfield, Pend Oreille, Clallam, Stevens, Adams, and Cowlitz.

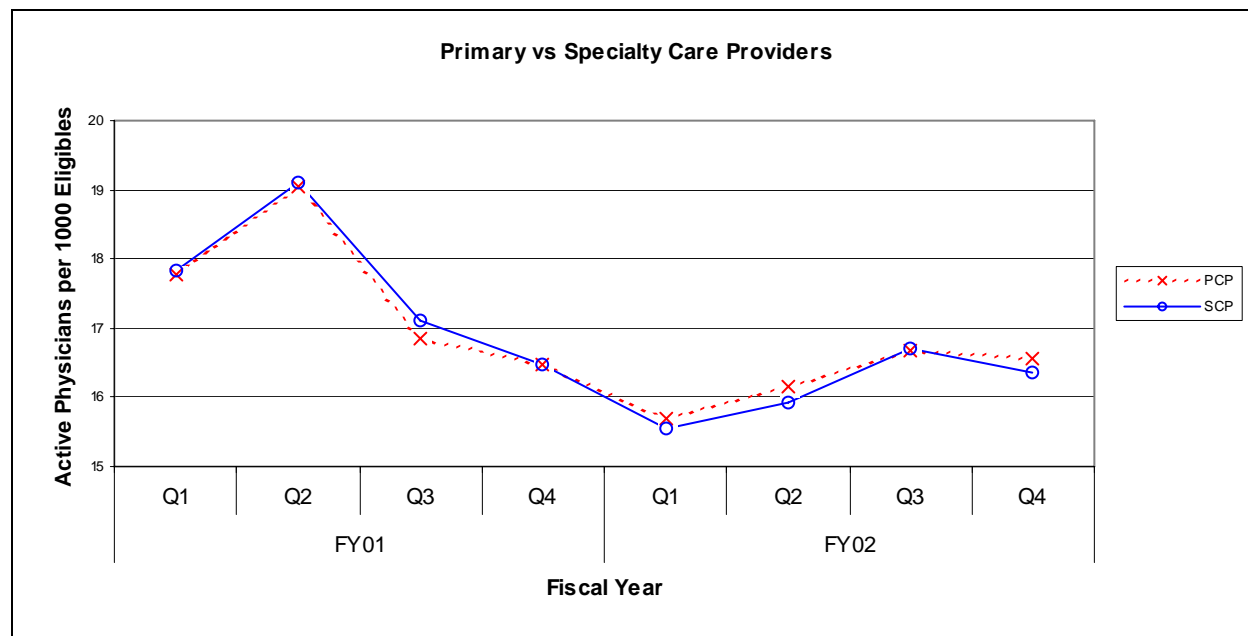


Figure 6 (H8): PCP per 1000 eligibles and likewise for SCP.

The ratio of physicians per 1,000 decreased for both primary care and specialists during SFY 2002 compared to 2001 (see Figure 6). The primary care ratio decreased 6.8%, from 17.5 per 1,000 clients in SFY 2001 to 16.3 in SFY 2002. The specialist ratio decreased 8.5%, from 17.6 per 1,000 clients to 16.1. The reductions were across most counties, with 31 (79.5%) counties having a reduction in primary care providers and 32 (82.1%) counties having a reduction in the ratio of specialists. (See Appendix H for by-county comparison of primary care and specialists per 1,000 clients.)

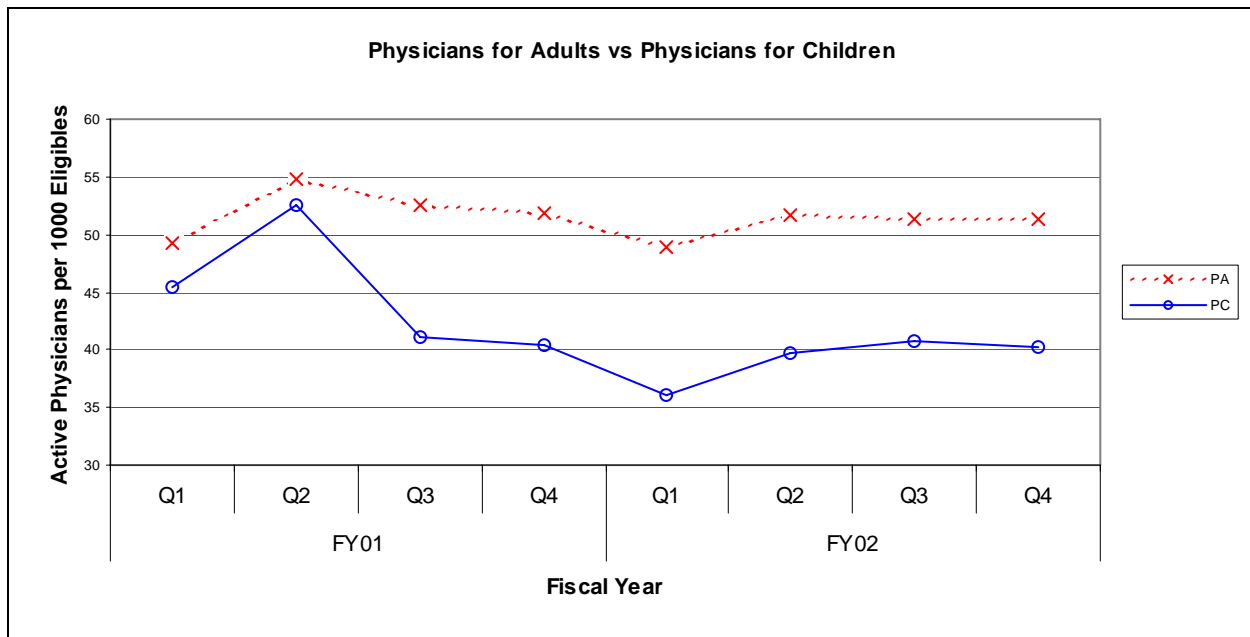


Figure 7(E11): PA per 1000 eligibles and likewise for PC.

The ratio of physicians per 1,000 decreased for both adult and children during SFY 2002 compared to 2001 (see Figure 7). The primary care ratio decreased 2.5%, from 52.1 per 1,000 clients in SFY 2001 to 50.8 in SFY 2002. The children's ratio decreased 12.5%, from 44.8 per 1,000 clients to 39.2. The reason for the significant decrease in the children's ratio is due to a significant client caseload increase (19.4%) during the SFY 2001-2002 period. (See Appendix E for by-county comparison of providers serving adults and children per 1,000 clients.)

Measure Three: Distribution of visits provided across active physicians

Figure 8 shows the distribution of visits across all physicians and ARNPs. The top (25%) quartile is used because most (approximately 70%) of the visits were provided by this quartile, and using this quartile provides a clearer picture to see whether changes are occurring.

The distribution of physician/ARNP visits was about the same during SFY 2001 (70.7%) and 2002 (71.0%). Ten percent (10%) of the active physicians/ARNPs provided 48% of the total number of visits, 25% of the physicians/ARNPs provided 72% of the total number of visits, 50% of the physicians/ARNPs provided 91% of the visits, and 75% of the physicians/ARNPs provided 98% of the visits.

On a by-county basis, there was a significant difference in the percentage of services provided by the top quartile of physicians/ARNPs. (See Appendix D for by-county comparison of services provided by top quartile of providers.) During SFY 2002, this ranged from 52.7% in San Juan County to 87.2% in Adams County. There was not a strong correlation between physicians/ARNPs per 1,000 clients and the distribution of visits by the top quartile of physicians/ARNPs per-county.

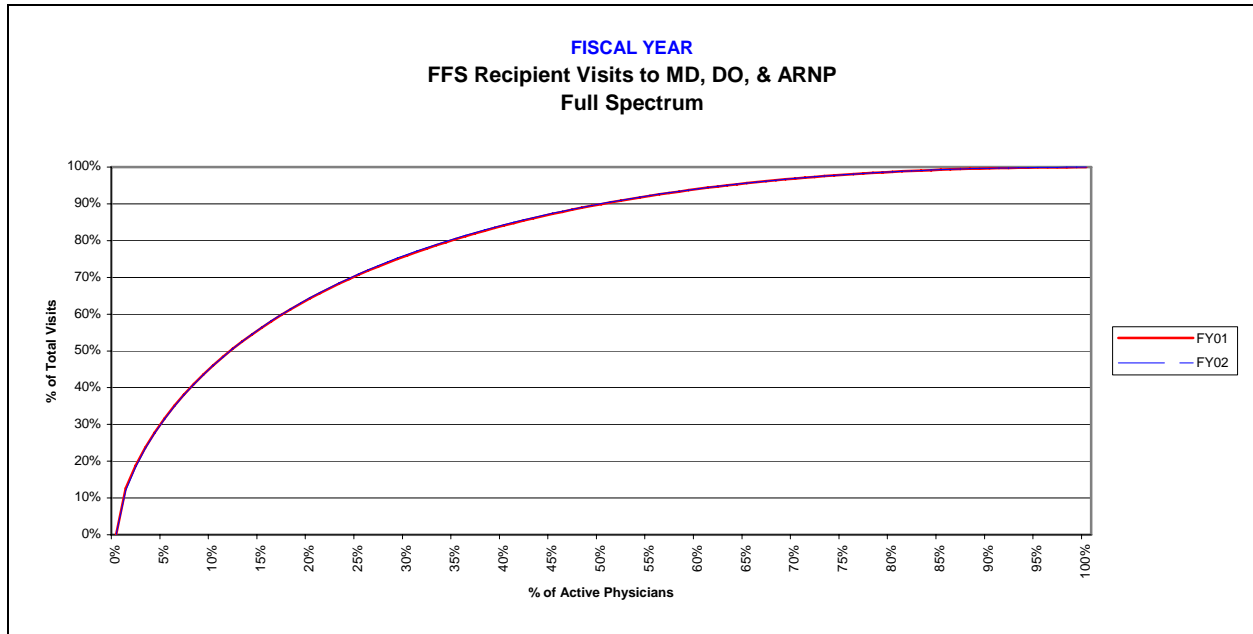


Figure 8 (C2): State fiscal year (SFY) 2001 and 2002 comparison of all active providers (MD, DO, and ARNP).

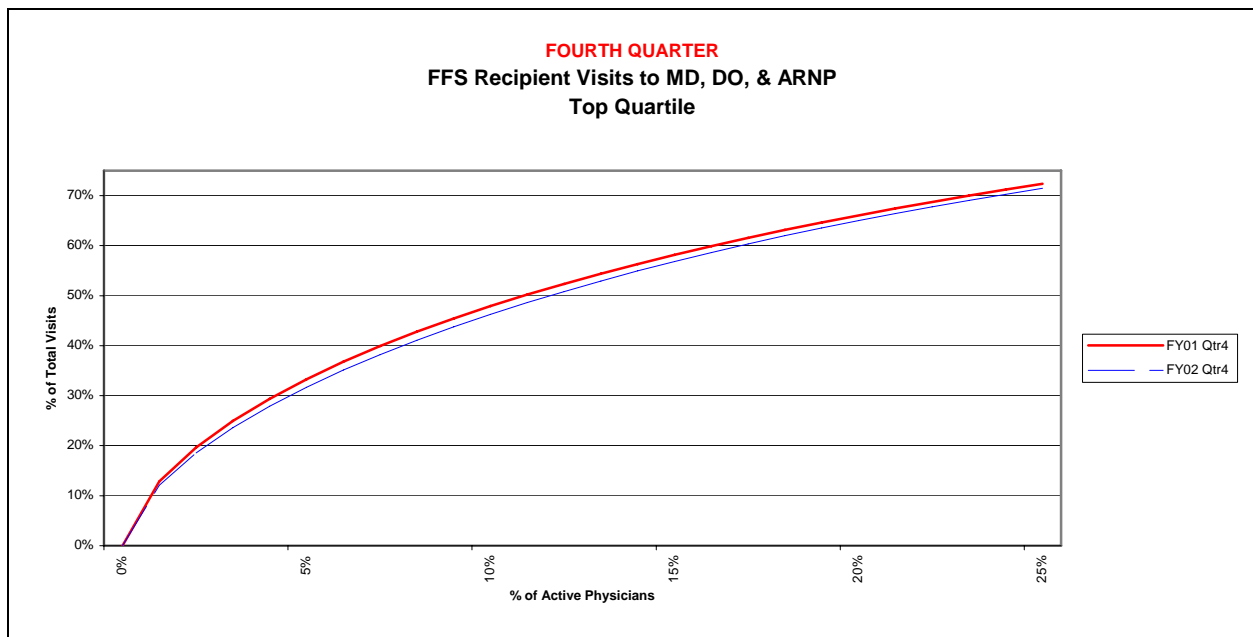


Figure 9 (C6): Comparison of fourth quarter SFY 2001 and 2002.

During the most current quarter, there was a slight reduction (0.9%) in the percent of visits provided by the top quartile of providers (see Figure 9). That reduction was achieved during a period when the number of physicians/ARNPs increased 2.3% and the number of physicians/ARNPs per 1,000 clients decreased 0.3%. This would indicate that access was stable for the most current period.

During the most current quarter, the percentage ranged from 53.7% in San Juan County to 96.7% in Wahkiakum, with no correlation between this measure and the population of the counties.

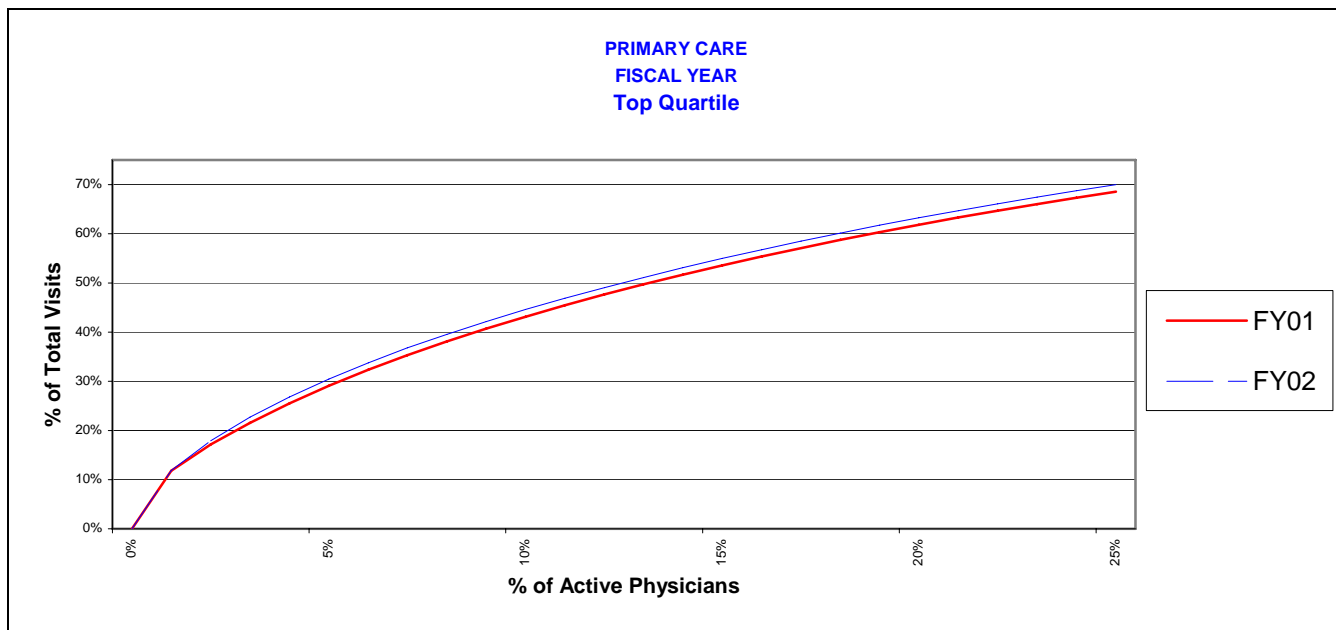


Figure 10 (I1): The percent of FFS visits provided by most active PCP, meaning top 5% of the most active PCP took care of nearly 30% of the visits in FY01 Qtr1.

The distribution of visits provided by the top 25% of physicians/ARNPs is a little better for primary care than for specialty care (see Figures 10 and 11). In SFY 2002, the top 25% of primary care physicians/ARNPs provided 70.0% of the services, while the top 25% of specialists provided 73.0% of care for the period.

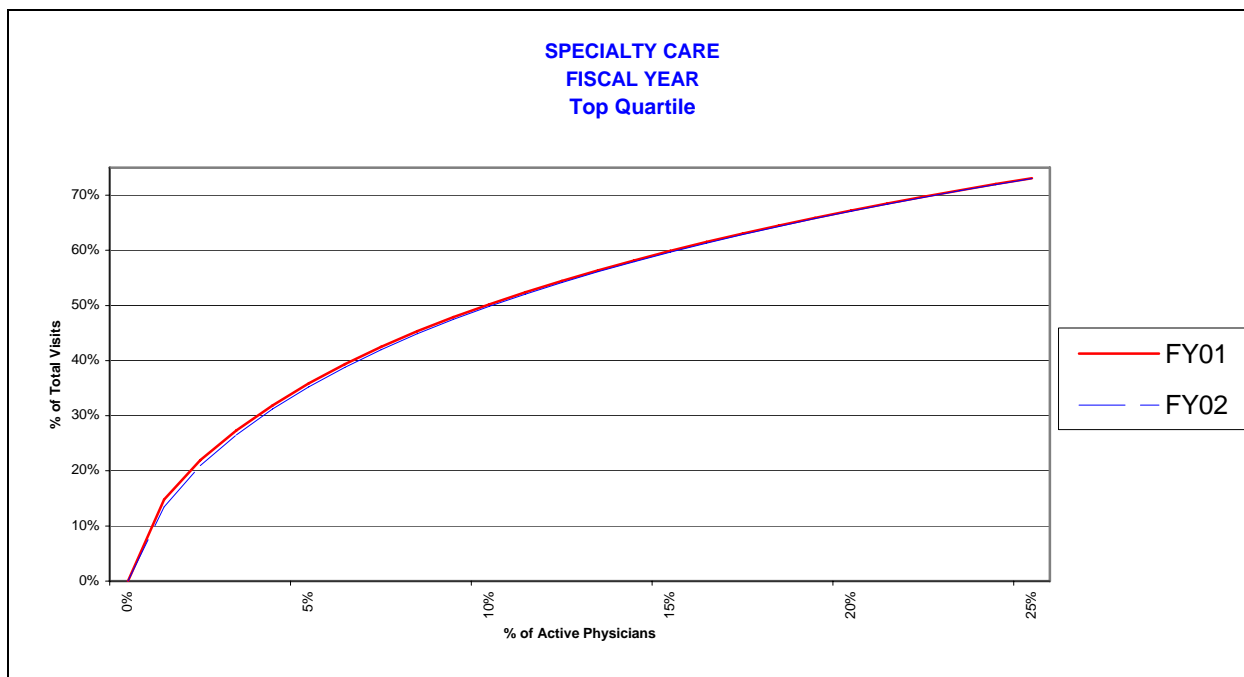


Figure 11 (J1): The percent of FFS visits provided by most active CP, meaning top 5% of the most active PSCP took care of over 30% of the visits in FY01 Qtr1.

There was not a material change in the distribution from SFY 2001 to 2002 for either primary care or specialist providers. About half the counties experienced a slight improvement and the other half got slightly worse on this measure. In comparing SFY 2001 to SFY 2002, there was a slight (0.3%) increase in the percentage of visits provided by the top quartile of physicians, from 70.7% to 71.0%. Twenty-seven (69.2%) percent of the counties experienced an increase in this measure. Four counties (Skamania, Ferry, Garfield and San Juan) had a significant increase in their respective percent of visits.

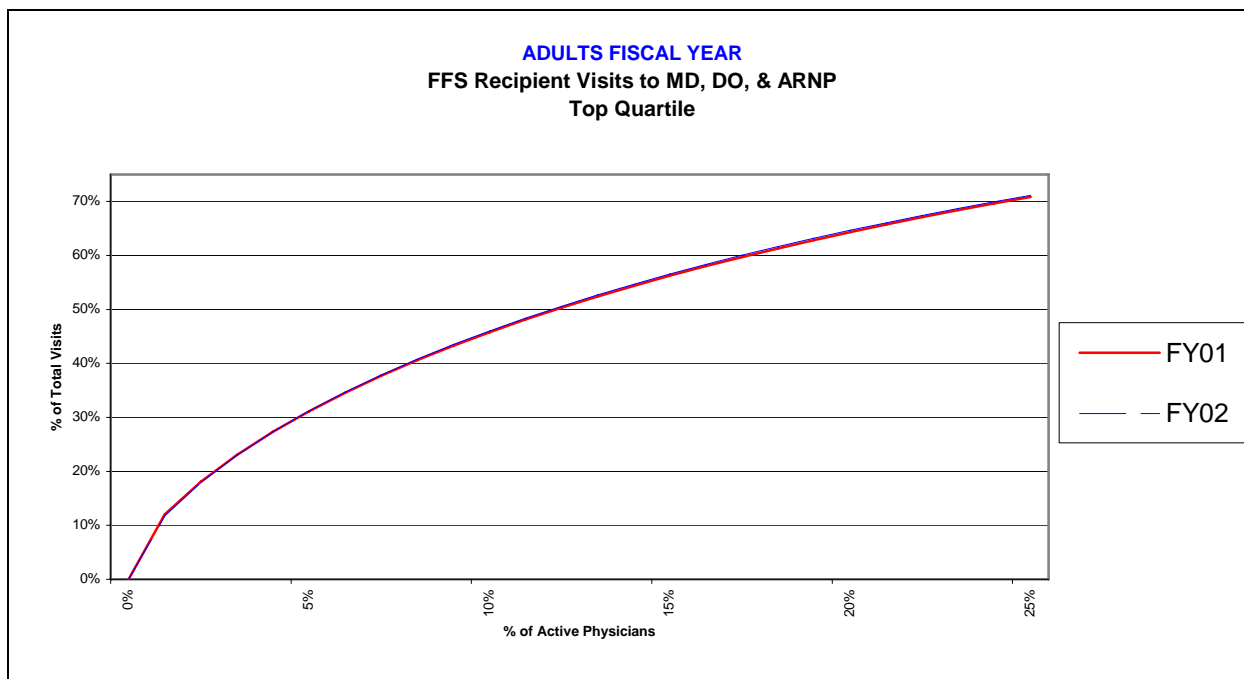


Figure 12 (F1): The percent of FFS visits provided by most active physicians for adults, meaning top 5% of most active physicians took care of nearly 30% of the visits in FY01 Qtr1.

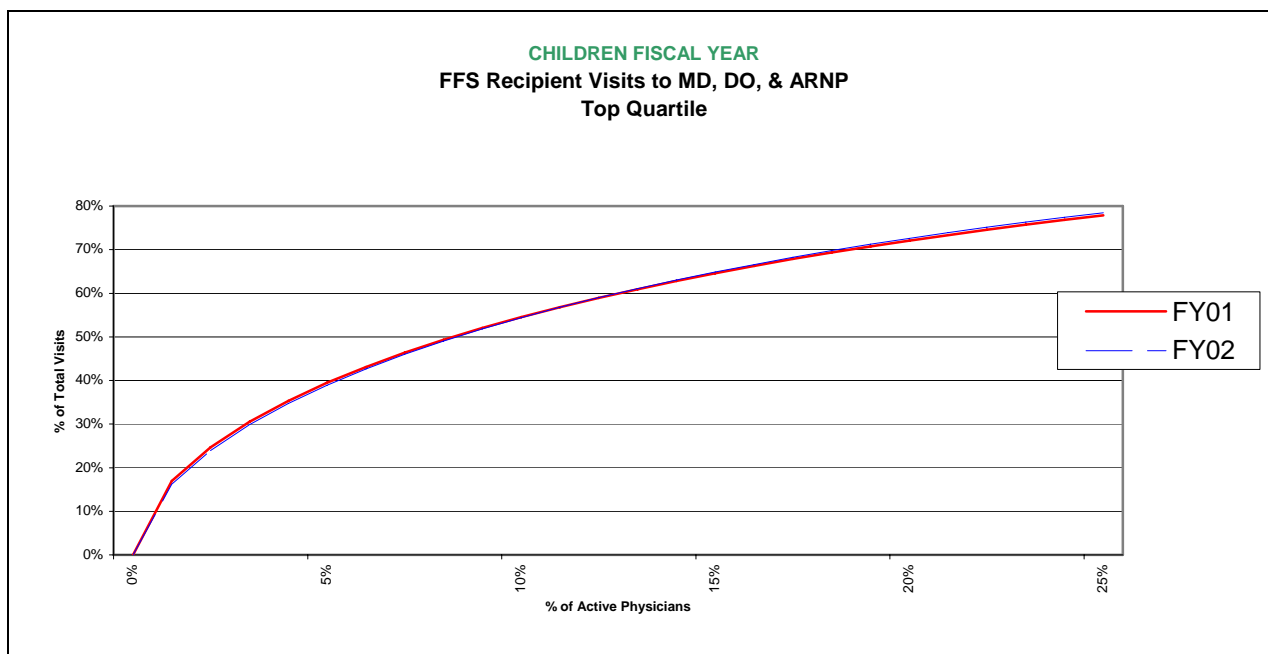


Figure 13 (G1): The percent of FFS visits provided by most active physicians for children, meaning top 5% of most active physicians took care of nearly 30% of the visits in FY01 Qtr1.

There was a difference in the percent of adult visits provided by the top quartile of physicians/ARNPs compared to visits by children (see Figures 12 and 13). During SFY 2002, the top quartile of physicians provided 71.2% of all visits for adults compared to 78.5% of visits for children. However, there was not a material difference between SFY 2001 and 2002 in the percent of adult visits or children visits provided by the top quartile of physicians/ARNPs.

C. SFY 2001-2002 BASELINE MEASURE

MAA will be generating quarterly updates of its three access measures to monitor potential changes in access on a statewide and by-county basis. Based on a review of the past five-year period, the SFY 2001 and 2002 periods provide a reasonable base-period to compare future changes.

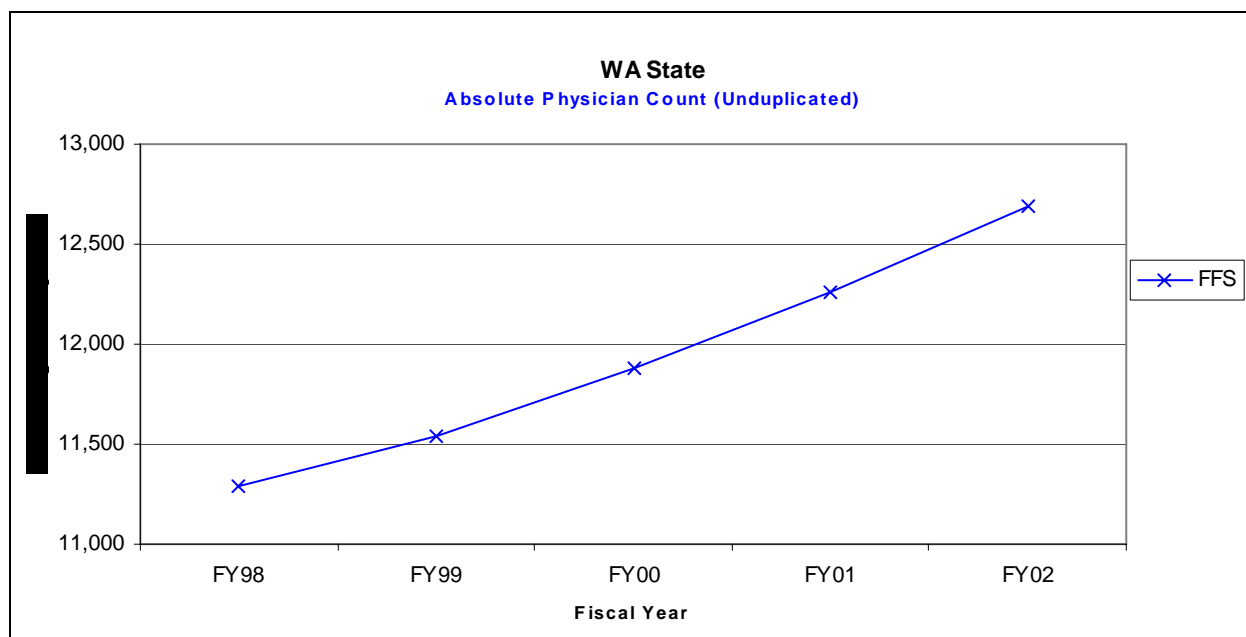


Figure 14 (A6): Active FFS physicians on a SFY basis.

The average growth in the number of active physicians and ARNPs during this recent two-year period is consistent with the overall average annual growth in providers over the total five-year period (See Figure 14). The number of active participating MAA FFS physicians and ARNPs has increased 12.4% over the past five-year period, from 11,289 in SFY 1998 to 12,687 in SFY 2002. The number of active physicians and ARNPs increased at 3.5% per year from SFY 2001 to 2002. Over the five-year period, the number of active physicians and ARNPs increased 3.1% per year.

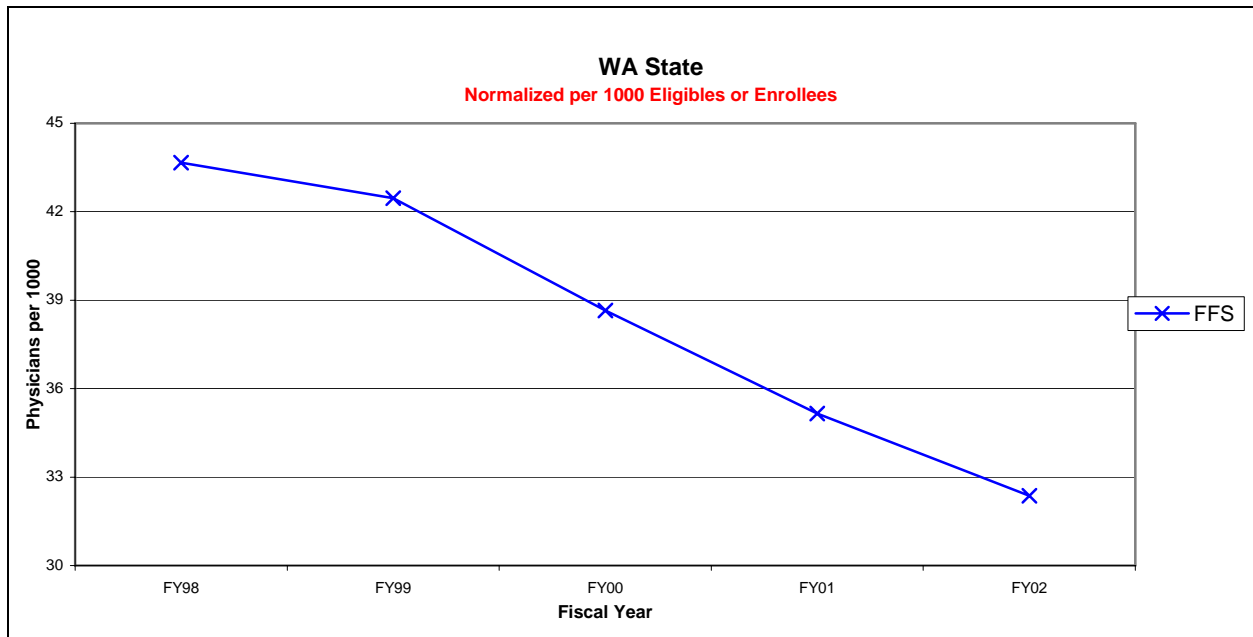


Figure 15 (A7): Physicians per 1000 FFS Eligibles on a SFY basis.

Similarly, the 7.9% per year reduction in active physicians/ARNPs per 1,000 clients in the most recent two-years is comparable to the average reduction of 6.6% per year for the five-year period (See Figure 15). In all years, the reduction in active physicians/ARNPs per 1,000 clients was due to the greater increase in FFS clients.

Figure 16 shows only the top quartile of Medical Assistance FFS physicians and ARNPs for the five-year period from SFY 1998 through 2002. There has been a slight desirable reduction in the percent of visits provided by the top quartile during the five-year period, from 73.1% in SFY 1998 to 71.9% in SFY 2002. This reduction occurred at a time when the number of physicians/ARNPs per 1,000 clients decreased 26%, from 43.7 per 1,000 to 32.4 per 1,000. This indicates that more physicians and ARNPs are providing relatively more visits.

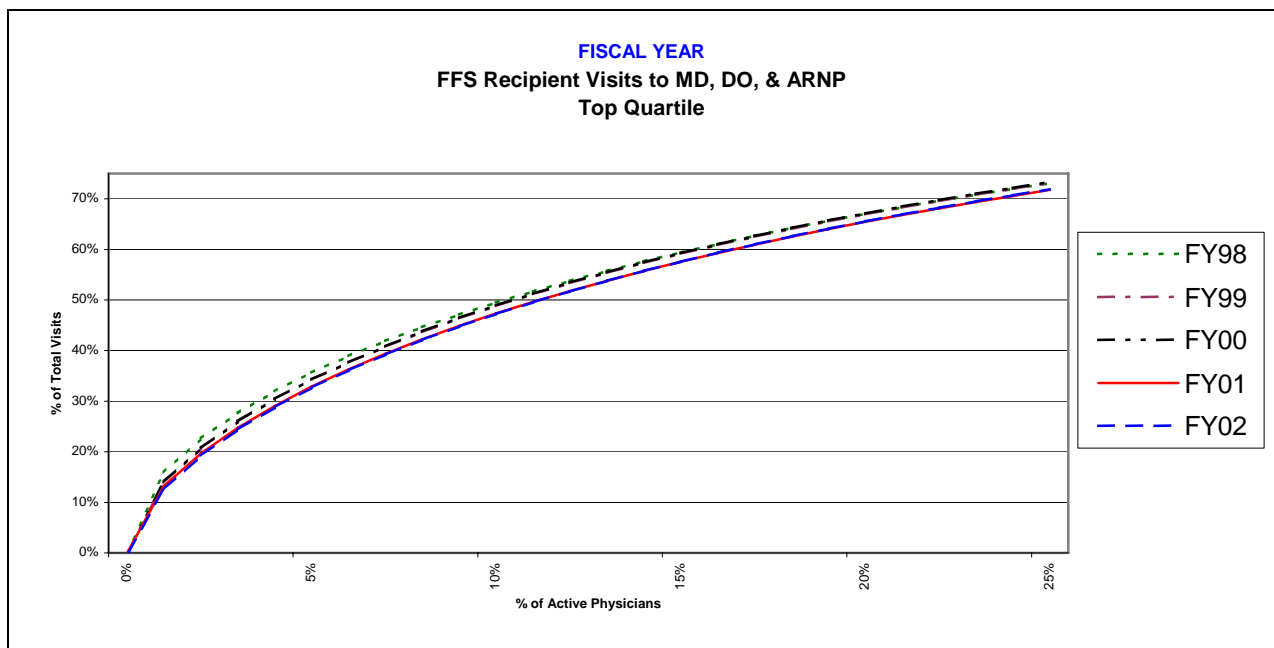


Figure 16 (C1): Fiscal year comparisons of top quartile distribution for Washington State

III. PHASE ONE CONCLUSIONS & NEXT STEPS

Overall, the number of active MAA FFS physicians and ARNPs increased over the period from SFY 1998 through SFY 2002, with an average increase of 3.0% per year, from 11,289 to 12,687. This increase had continued over the most recent quarter (SFY2003-Quarter 4), at a rate of 2.4% compared to the prior year's 4th quarter.

These trends occurred for both primary care and specialist providers during the SFY 2001 to 2002 period, including the most recent quarter. Primary care providers grew at a somewhat greater rate (4.2%) for SFY 2001-02 than specialists (2.7%).

These trends also occurred for adult and children's providers. The number of providers increased 3.4% for adults and 5.6% for children during the SFY2001-02 period.

The increase in active physicians and ARNPs was offset by the greater increase in eligibles. This caused the ratio of active physicians per 1,000 clients to decrease 25.9% from 43.7 per 1,000 clients to 32.3 per 1,000 from SFY 1998 through SFY 2002. The most recent quarter's ratio (32.8 per 1,000) is essentially the same as the prior year's quarter (32.9 per 1,000). These trends occurred for both primary care providers and specialists. These trends also occurred for both adult and children's providers.

Although there has been a reduction in the number of active MAA FFS physicians/ARNPs per 1,000 clients, it still compares favorably statewide with HO and state employees' coverage. There has been no relative decay in active physicians/ARNPs compared to HO, PEBB and UMP. In comparison to MAA's FFS ratio of 32.3 per 1,000 in SFY 2002, PEBB was 19.1 per 1,000 and HO was 7.2 per 1,000. Only UMP had a higher (40.4 per 1,000) ratio of physicians and ARNPs.

There is a significant difference in the ratio of physicians/ARNPs per 1,000 clients across counties. There will be a need to do detailed by-county comparisons to ensure that there is no decay in more rural counties over time.

The distribution of physician/ARNP visits has been relatively stable from SFY 1998 to 2002. On average over this 5-year period, 10% of the active physicians/ARNPs provided 48% of the total number of visits, 25% of the physicians/ARNPs provided 73% of the total number of visits, 50% of the physicians/ARNPs provided 91% of the visits, and 75% of the physicians/ARNPs provided 98% of the visits.

The MAA Access Measurement Workgroup will be developing a product system and standard reports to monitor access every six months. It is intended that the three access measures will be measured overall, by primary and specialty providers, and by adults and children.

In addition, the analysis will incorporate biennial reviews of emergency room admissions to assess whether there is a correlation between changes in physician access and emergency room utilization. The hypothesis is that MAA FFS clients facing difficulty in accessing primary and specialty care may seek needed care in hospital emergency rooms.

Based on a review of SFY 2003 emergency room admissions and the FFS distribution measure, the Access Workgroup has concluded there is a need to develop additional metrics to measure the utilization on physicians. The new metric will measure the ratio of number of FFS visits per quarter per 1,000 active physicians and the number of visits per 1,000 eligible FFS clients. The measure will parallel the three existing measures by comparing the utilization for FFS primary care and specialty care. The utilization measure also will be compared for adults and children. This new measure will be introduced in the CY 2003 update in September 2004.

APPENDICES

FFS AGGREGATE

Appendix A: By-County Number of Providers, Number of Clients, and Providers Per 1000 Clients Across Four Different Health Plans. Comparisons of Medicaid FFS, Medicaid Managed Care, HCA Managed Care PEBB and HCA FSS UMP.

Appendix B: By-County Charts of the Number of Providers, Number of Clients, and Providers Per 1000 Clients for FFS Only. Comparisons of Medicaid FFS, Medicaid Managed Care, HCA Managed Care PEBB and HCA FSS UMP.

Appendix C: Graphical Presentation, Percent of Total Visits Provided by Top 25% of Active Providers.

Appendix D: Tabular By-County Presentation, Percent of Total Visits Provided by Top 25% of Active Providers.

CLIENTS: ADULTS vs. CHILDREN

Appendix E: By-County Number of Providers Serving Adults and Children; By-County Number of Providers Per 1000 Serving Adults and Children.

Appendix F: Top Quartile Distribution Curve for Providers Serving Adults.

Appendix G: Top Quartile Distribution Curve for Providers Serving Children.

PROVIDERS: PCP vs. SCP

Appendix H: By-County Number of Primary Care Providers (PCP) and Specialty Care Providers (SCP); By-County Number of PCP and SCP Providers Per 1000.

Appendix I: Top Quartile Distribution Curve for PCP.

Appendix J: Top Quartile Distribution Curve for SCP.

Appendix K: By-County Percent of Visits Provided By Top Quartile PCP.

Appendix L: By-County Percent of Visits Provided By Top Quartile SCP.